GlobalPass Healthcare Plans for Latin America
Valid from 1st May 2019

INDIVIDUAL
Benefit Guide

Allianz Care

Welcome

You and your family can depend on Allianz Care, as your international health insurer, to give you access to the best care possible.

This guide consists of two parts: "How to use your cover" is a summary of all important information you are likely to use on a regular basis. "Terms and conditions of your cover" explains your cover in more detail.

To make the most of your international healthcare plan, please read this guide in conjunction with your Insurance Certificate and Table of Benefits.

HOW TO USE YOUR COVER

TERMS AND CONDITIONS OF YOUR COVER

HOW TO USE YOUR COVER

MEMBER SERVICES

We believe in making a difference by providing you with the superior level of service that you deserve, anytime, anywhere!

In the following pages we describe the full range of member services we offer. Discover what is available to you, from our MyHealth app to the online services.

Talk to us, we love to help!

Our multilingual Helpline is available 24 hours a day, 7 days a week to handle any questions about your policy or if you need assistance in case of an emergency.

Helpline

Phone: +353 1 630 1301
For our latest list of toll-free numbers, please visit:
www.allianzworldwidecare.com/toll-free-numbers

Email: client.services@allianzworldwidecare.com

Fax: +353 1 630 1306

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

MyHealth app

Our pioneering MyHealth app has been designed to give you easy and convenient access to your cover, no matter where you are. With MyHealth app you can access the following features from your mobile device:

MY CLAIMS
Submit your claims in 3 simple steps and view your claims history.

MY CONTACTS
Access our 24/7 multilingual Helpline and local emergency numbers.

FIND A HOSPITAL
Locate medical providers nearby and get GPS directions.

SYMPTOM CHECKER
For a quick and easy evaluation of your symptoms.

Other Services *- access your policy documents and your Membership Card on the go, look up the local equivalent names of branded drugs and translate common ailments into one of 17 languages.*

All personal data within the MyHealth App are encrypted for data protection. Most features are accessible even when offline.

GETTING STARTED

Download – you can download the app from the App Store or Google Play, by simply searching for "Allianz MyHealth" and following the on-screen instructions.

Initial setup – once downloaded, open the app and provide your policy number. Then, if prompted, register to receive a username and temporary password. Otherwise, please insert the login details available from your Membership Pack. When requested, change the temporary password provided to something you can easily remember. If you re-install the app or setup the app on another device, please use this setup information again. Please note that you can also use these details to login to our Online Services.

Set PIN – finally, set your own unique PIN number. In the future, this PIN number will be all you need to access the Allianz MyHealth app and all its features

For more information, please visit:

www.allianzworldwidecare.com/myhealth

Download on the App Store

GET IT ON Google Play

Online Services

You can access our secure Online Services from the comfort of your home. Our Online Services allows you to:

- View and amend your personal details online.
- Download your policy documents, including your Membership Card.
- View your Table of Benefits and check how much remains payable under each benefit.
- Confirm the status of any claims submitted to us and view claims related correspondence.
- Pay your premiums by credit card and update your credit card details.

To access our secure Online Services, please log on to **my.allianzworldwidecare.com** and:

1. Login using the unique username and temporary password included in your Membership Pack.
2. When requested, change the temporary password provided to something you can easily remember. Please keep this information safe, you'll need it again! Please note that you can also use these details to login to our MyHealth App.
3. Click on "login" and browse away!

If you have not received a Membership Pack, go to my.allianzworldwidecare.com, select "Register" and enter the information requested. Your username and temporary password will be sent to the email address we have on record for you.

Web-based member services

On our website you can **search for medical providers, download forms and access our BMI calculator**. You are not restricted to using the medical providers listed on our website.

www.allianzworldwidecare.com/members

Medi24

This medical advice service, provided by an experienced medical team, offers information and advice on a wide range of topics including blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, oncology, disability, speech, fertility, pediatrics, mental health and general health. Medi24 is available 24/7 in English, German, French and Italian.

+44 (0) 208 416 3929

For policy or cover related queries (e.g. benefit limits or the status of a claim), please contact our Helpline.

COVER OVERVIEW

We understand the importance of your own and your family's health. Below is a summary to help you understand the scope of your health cover.

What am I covered for?

You are covered for all benefits indicated in your Table of Benefits. Pre-existing conditions (including any pre-existing chronic conditions) are generally covered unless we indicate otherwise in your policy documents. If in doubt, please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

Cover is provided for the treatment of congenital and hereditary conditions, as outlined in the "Definitions" section of this guide. The maximum limit for congenital and hereditary conditions is stated in the Table of Benefits.

All congenital and hereditary conditions must be declared in the relevant application form at application stage. Please note that cover may not include pre-existing congenital and hereditary conditions if pre-existing conditions are not covered under your plan (please see the "Pre-existing conditions" definition for further information).

Please note that cover of congenital and hereditary conditions is subject to the in-patient and out-patient benefits listed in your Table of Benefits. Pre-authorization is required for in-patient treatment.

Where can I receive treatment?

You can avail of treatment in any country within your area of cover (which is indicated in your Insurance Certificate).

If the treatment you require is available locally, but you choose to travel to another country within your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; apart from your travel expenses. However, if the eligible treatment is not available locally, and "Medical evacuation" is included in your cover, travel costs to the nearest center of excellence are also covered. In order to seek reimbursement for medical and travel expenses incurred, you will need to complete and submit the Pre-authorization Form before traveling.

As an expatriate living abroad, you are covered for eligible costs incurred in your home country, provided that your home country is within your area of cover.

What are benefit limits?

Your cover may be subject to a maximum plan benefit. This is the maximum we will pay in total for all benefits included in the plan. Although many benefits included in your Table of Benefits are covered in full, some are capped to a specific amount (e.g. US$30,000). This specific amount is a benefit limit.

For further information on benefit limits please refer to the "Benefit limits" section of this guide.

Is your family growing? We have you covered!

Are you getting married or going to have a baby? Congratulations!

You can add your spouse or partner to your policy by simply completing our Application Form, available at:

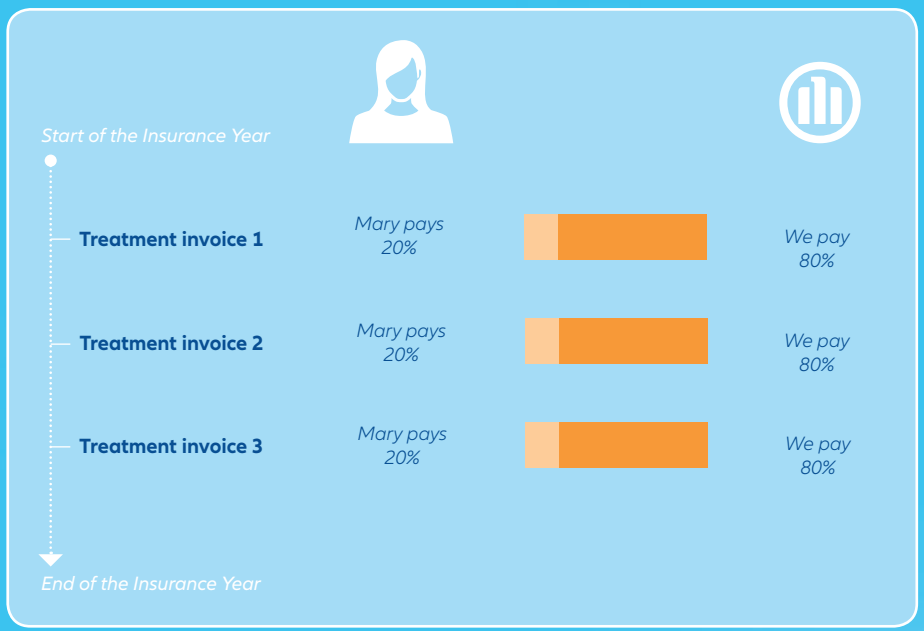
www.allianzworldwidecare.com/application

To add a new born child to your policy, simply send an email to our underwriting team, including a copy of the birth certificate. When adding a new born child to your policy, make sure to send your request within six weeks of the date of birth, to ensure that the child is accepted for cover without medical underwriting and for cover to start from birth. For further information on how to add a dependant, including important information in how to add multiple babies, adopted and foster children, please refer to the "Adding dependants" section of this guide.

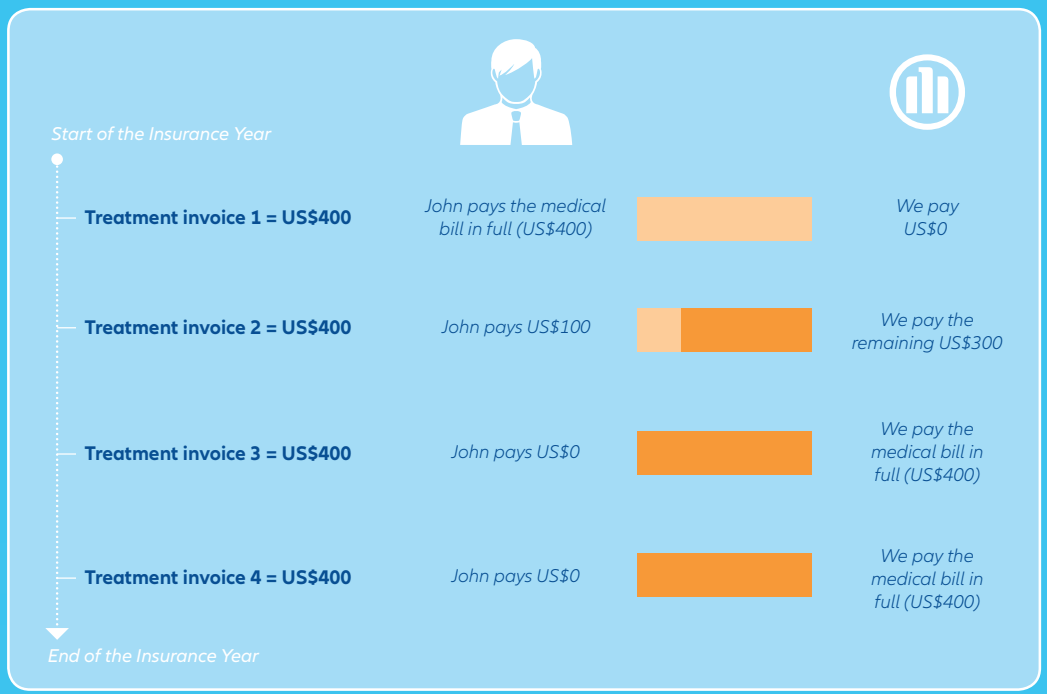
What are deductibles and co-payments?

Some plans and benefits may be subject to co-payments and/or a deductible. If your plan includes any, this will be confirmed in your Table of Benefits.

A co-payment is when you pay a percentage of the medical costs. In the following example, Mary requires several dental treatments throughout the year. Her dental treatment benefit has a 20% co-payment, which means that we will refund 80%. The total amount payable by us may be subject to a maximum plan benefit limit.



A **deductible** is a fixed amount that the insured person must pay per period of cover (when paying for their medical bills) before we begin to pay for the medical expenses. In the following example, John needs to receive medical treatment throughout the year. His plan includes a US$500 deductible.



Benefits subject to a deductible are marked in your Table of Benefits with an A. Where the deductible applicable to your policy is "per family", it will apply to the first claim(s) submitted by any person covered under your plan.

Insurer contribution
Insured person contribution

SEEKING TREATMENT?

We understand that seeking treatment can be stressful. By following the process below, we can look after the administration and you can concentrate on getting better.

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm which benefits are available to you, however, you can always call our Helpline if you have any queries.

Some treatments require pre-authorization

Your Table of Benefits will indicate what treatments are subject to pre-authorization through submission of a Pre-authorization Form. Usually these are in-patient and high cost treatments. The Pre-authorization process helps us to assess each case, organize everything with the hospital before your arrival and facilitate direct payment of your hospital bill, where possible.

Getting in-patient treatment

(pre-authorization applies)

Download a Pre-authorization Form from our website:
www.allianzworldwidecare.com/members

Send the completed form to us at least **five working days before** treatment. Scan and email, fax or post (details on the form).

We contact your medical provider directly to arrange settlement of your bills (where possible).

We can also take Pre-authorization Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if Pre-authorization is not obtained. Full details of our Pre-authorization process can be found in the Terms and Conditions section of this document.

If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support.

Either you, your physician, one of your dependents or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalization. Pre-authorization Form details can be taken over the phone when you call us.

Claiming for your out-patient, dental and other expenses

If your treatment does not require pre-authorization, just pay the bill and claim the expenses from us. In this case, simply follow these steps:

Receive your medical treatment and pay the medical provider.

Get an invoice from your medical provider.
This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Claim back your eligible costs via our MyHealth app.
Simply provide a few key details, take a photo of your invoice(s) and press 'submit'.

As an alternative to MyHealth app, you can also claim your treatment costs by completing and submitting a Claim Form, downloadable at:

www.allianzworldwidecare.com/members

You will need to complete section 5 and 6 of the Claim Form only if the information requested in those sections is not already provided on your medical invoice.

Please send the Claim Form and all supporting documentation, invoices and receipts to us by email, fax or post (details on the form).

Please refer to "Medical Claims" in the Terms and conditions of your cover section of this guide for additional information about our claims process.

Quick claim processing

We can process a claim and issue payment instructions to your bank within 48 hours, when all required information has been submitted. However, without the diagnosis, we cannot process your claim promptly, as we will need to request these details from you or your doctor. Please make sure you include the diagnosis on your claim!

We will email or write to you to let you know when the claim has been processed.


EXIT
AMBULANCE

Evacuations

At the first indication that a medical evacuation is required, please call our 24 hour Helpline and we will take care of everything. Given the urgency of an evacuation, we would advise that you call us, however, you can also contact us by email.

When emailing, please include "*Urgent – Evacuation*" in the subject line. Please contact us before talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. In the event that evacuation services are not organized by us, we reserve the right to decline the costs.

+353 1 630 1301

medical.services@allianzworldwidecare.com

And if I need treatment in the USA?

For healthcare treatment in the USA, Allianz Care has established a partnership with Olympus Managed Healthcare (OMHC), offering access to an exclusive network of medical facilities and healthcare providers on a direct billing basis. A full list of providers in this network is available online.

globalpass.omhc.com

You are not restricted to using this network. However, if you have a GlobalPass Connect plan and choose a provider outside of the network, we will only reimburse 60% of the medical expenses.

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply contact us on our USA number:

(+1) 800 541 1983
(toll-free from the USA)

Alternatively, you can request a call back by clicking on "Contact me" at **globalpass.omhc.com** and following the instructions on screen.

When traveling to the USA for treatment, it is recommended that you contact us at least 10 working days prior to travel so that we can ensure there will be no delays at the time of admission.

OLYMPUS

You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your plan. To register and obtain your discount pharmacy card, simply go to the following website and click on “Print Discount Card”.

http://members.omhc.com/awc/prescriptions.html

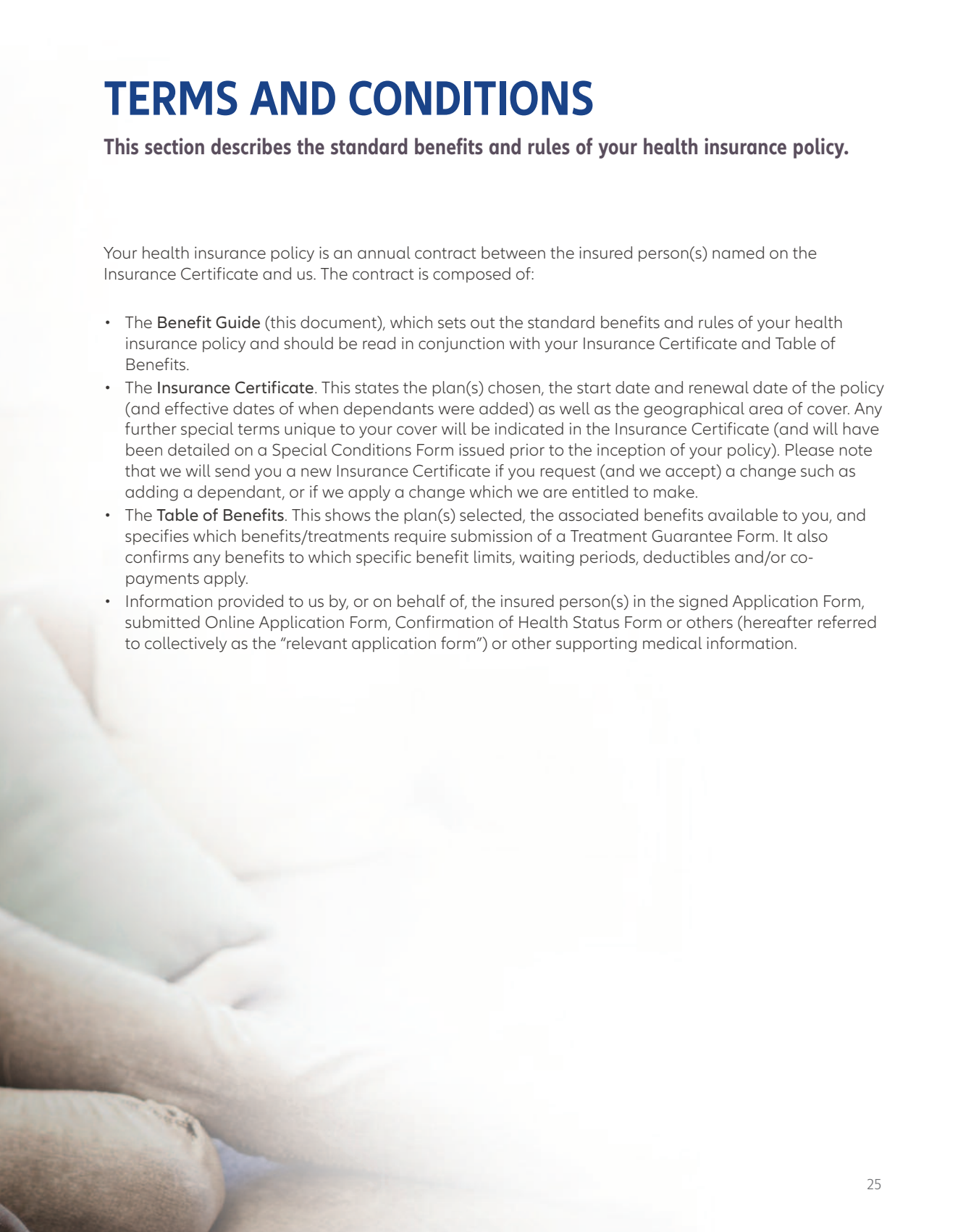
TERMS AND CONDITIONS OF YOUR COVER

TERMS AND CONDITIONS

This section describes the standard benefits and rules of your health insurance policy.

Your health insurance policy is an annual contract between the insured person(s) named on the Insurance Certificate and us. The contract is composed of:

- The **Benefit Guide** (this document), which sets out the standard benefits and rules of your health insurance policy and should be read in conjunction with your Insurance Certificate and Table of Benefits.
- The **Insurance Certificate**. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added) as well as the geographical area of cover. Any further special terms unique to your cover will be indicated in the Insurance Certificate (and will have been detailed on a Special Conditions Form issued prior to the inception of your policy). Please note that we will send you a new Insurance Certificate if you request (and we accept) a change such as adding a dependant, or if we apply a change which we are entitled to make.
- The **Table of Benefits**. This shows the plan(s) selected, the associated benefits available to you, and specifies which benefits/treatments require submission of a Treatment Guarantee Form. It also confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information provided to us by, or on behalf of, the insured person(s) in the signed Application Form, submitted Online Application Form, Confirmation of Health Status Form or others (hereafter referred to collectively as the "relevant application form") or other supporting medical information.



YOUR COVER EXPLAINED

The plans that you selected are indicated in your Table of Benefits, which lists all the benefits you are covered for and any applicable limits. For an explanation of how your benefit limits apply to your plan, please see the "Benefit limits" paragraph below.

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this document).
- Any special conditions indicated on your Insurance Certificate (and on the Special Condition Form issued prior to policy inception, where relevant).

What we cover

a) The extent of your cover is determined by your Table of Benefits, the Insurance Certificate, any policy endorsements, these policy terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.

b) This policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce or decline the amount payable by us.

c) This policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

When cover starts for you and your dependants

Our acceptance of your application for cover is confirmed when we issue your Insurance Certificate and your cover is valid from the start date shown on the certificate. Please note that no benefit will be payable under your policy until the initial premium has been paid, with subsequent premiums being paid when due.

If any other person is included as a dependant under your membership, their membership will start on the effective date as shown on your most recent Insurance Certificate which lists them as a dependant. Their membership may continue for as long as you remain the policyholder and as long as any child dependants remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday; or up until the day before their 24th birthday if they are in full time education. At that time, they may apply for cover in their own right, should they wish to do so.

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits:

- The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan.
- Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "80% refund, up to US$3,000".

Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

If you are covered for maternity benefits, these will be stated in your Table of Benefits along with any benefit limit and/or waiting period that applies. Benefit limits for "Routine maternity" and "Complications of pregnancy and childbirth" are payable on either a "per pregnancy" or "per Insurance Year" basis (this will be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and a pregnancy spans two Insurance Years, please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.
- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.
- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

CLAIMS AND TREATMENT GUARANTEE PROCESS

Medical claims

In relation to medical claims, please note that:

a) All claims should be submitted (via our MyHealth app or Claim Form) no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, claims should be submitted no later than six months after the date that your cover ended. Beyond this time we are not obliged to settle the claim.

b) Submission of a separate claim (via our MyHealth app or Claim Form) is required for each person claiming and for each medical condition being claimed for. Please note that as well as our hard and soft copy claim forms, if your company has selected our Online Services facility, members can now avail of our *MyHealth* app for fast and easy claims submission.

c) It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement, for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

d) If the amount to be claimed is less than the deductible figure under your plan, keep collecting all out-patient receipts and Claim Forms until you reach an amount in excess of your plan deductible, then forward to us all completed Claim Forms together with supporting receipts/invoices. Please note that if you have local cover in place (with another healthcare insurer), you can request that any eligible in-patient/day-care claims paid for by the other insurer are accepted as a contribution to the deductible amount on your healthcare plan with us. This only applies to eligible in-patient/day-care treatment received in a hospital or clinic. Please send us a copy of a detailed invoice from the hospital along with a statement or official document confirming contribution from your local insurer.

e) We cannot accept credit card receipts without invoices.

f) Please specify on the Claim Form the currency in which you wish to be paid. Unfortunately, on rare occasions, we may not be able to make a payment in the currency you requested on the Claim Form due to international banking regulations. In this instance we will review each case individually to identify a suitable alternative currency option. If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued, or we will use the exchange rate that applies on the date that claims payment is made.

   Please note that we reserve the right to choose which currency exchange rate to apply.

g) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of your policy, after taking into consideration any Treatment Guarantee requirements. Any deductibles or co-payments outlined in the Table of Benefits will be taken into account when calculating the amount to be reimbursed.

h) If you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.

i) You and your dependents agree to assist us in obtaining all necessary information to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in

strict confidence. We reserve the right to withhold benefits if you or your dependents have not honored these obligations.

Treatment needed as a result of somebody else's fault

If you are claiming for treatment that is needed when somebody else is at fault, you must write and tell us as soon as possible; e.g. if you need treatment for an injury suffered in a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault so that we can recover, from the other insurer, the cost of the treatment paid for by us. If you are able to recover the cost of any treatment for which we have paid, you must repay that amount (and any interest) to us.

Treatment Guarantee

Some of the benefits available to you require pre-authorisation through submission of a Treatment Guarantee Form. In your Table of Benefits, these are usually marked with a 1 or a 2.

For your convenience, see below the treatments/benefits which normally require pre-authorisation through submission of a Treatment Guarantee Form (this may vary depending on the cover selected for you, so please check your Table of Benefits to confirm):

- All in-patient benefits[1] listed (where you need to stay overnight in a hospital).
- Bariatric surgery or gastric bypass[2].
- Day-care treatment[2].
- Expenses for one person accompanying an evacuated person[2].
- Kidney dialysis[2].
- Long term care[2].
- Medical evacuation[2] (or repatriation[2], where covered).
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee is not needed for MRI scans unless you wish to have direct settlement.
- Nursing at home or in a convalescent home[2].
- Occupational therapy[2] (only out-patient treatment requires pre-authorisation).
- Oncology[2] (only in-patient or day-care treatment requires pre-authorisation).
- Organ transplant[1].
- Out-patient surgery[2].
- Palliative care[2].
- PET[2] (Positron Emission Tomography) and CT-PET[2] scans.
- Rehabilitation treatment[2].
- Repatriation of mortal remains[2].
- Routine maternity[2], complications of pregnancy and childbirth[2] (only in-patient treatment requires pre-authorisation).
- Specialised out-patient drugs[2].
- Travel costs of insured family members in the event of an evacuation[2] (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains[2].

Use of the Treatment Guarantee Form helps us to assess each case and facilitate direct settlement with the hospital.

Please note that unless agreed otherwise between your company and us, if Treatment Guarantee is not obtained, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed with a **1, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefit.
- For the benefits listed with a **2, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefit.

PAYING PREMIUMS

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You are required to pay the premium due to us in advance for the duration of your membership. The initial/first premium instalment is payable immediately after our acceptance of your application. Subsequent premiums are due on the first day of the chosen payment period. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your invoice, you should contact us immediately. We are not responsible for payments made through third parties.

Your premium should be paid in the currency you selected when applying for cover. If you are unable to pay your premium for any reason, please contact us on:

+353 1 630 1301

Changes in payment terms can be made at policy renewal, via written instructions, which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder to pay the amount due. Thereafter, we may terminate the contract in writing with immediate effect and shall thereby be exempt to pay benefits.

The effects of termination shall cease if the policyholder makes a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period.

Paying other charges

In addition to paying premiums, you also have to pay us the amount of any taxes, levies or charges relating to your membership (or new taxes, levies or charges that may be imposed after you join) that we are required by law to pay or to collect from you. The amount of any taxes, levies or charges that you have to pay us is shown on your invoice.

Please note that we may change the amount you have to pay us in respect of taxes, levies or charges at any time, if there is a change in the rate of any new tax, levy or charge is introduced or changed.

ADMINISTRATION OF YOUR POLICY

Adding dependants

You may apply to include any of your family members on the policy by completing the relevant application form.

Newborn infants (with the exception of multiple birth babies, adopted and fostered babies) will be accepted for cover from birth without medical underwriting, provided that we are notified within six weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy), has been insured with us for a minimum of six continuous months. To notify us of your intention to have your newborn child included on your policy, please email your request with a copy of the birth certificate to our Underwriting Team at:

@ underwriting@allianzworldwidecare.com

Notification of the birth after six weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. Please note that all multiple birth babies, adopted and fostered children will be subject to full medical underwriting and cover will only commence from the date of acceptance.

Following acceptance by our Underwriting team, we will issue a new Insurance Certificate to reflect the addition of a dependant, and this certificate will replace any earlier version(s) you may have from the start date shown on the new Insurance Certificate.

Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder will be required to complete an application form and full medical underwriting will apply. (Please refer to the section on "Death of the policyholder or a dependant" if this requested change is due to the death of the policyholder).

Death of the policyholder or a dependant

We hope you will never need to refer to this section; however, if a policyholder or a dependant dies, please inform us in writing within 28 days.

If the policyholder dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued). Alternatively, if they wish to, the next named dependant on the Insurance Certificate may apply to become the policyholder in his/her own right (if they meet the minimum age requirements), and include the other dependants under his/her membership. If they apply

to do this within 28 days we will, at our discretion, not add any further special restrictions or exclusions applicable to them, in addition to those which already applied to them at the time of the policyholder's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that member will be made, if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued).

Changes to premium, other charges or your cover

We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the method or frequency of payment. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increased level of cover.

Please note that we may change the amount you have to pay us in respect of taxes, levies or charges at any time, if there is a change in the rate of any new tax, levy or charge is introduced or changed.

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

If you want to change your level of cover, please contact us before your policy renewal date to discuss your options, as changes to cover can only be made at policy renewal. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire and/or to agree to certain exclusions or restrictions to any additional cover before we accept your application. If an increase in cover is accepted, an additional premium amount will be payable and waiting periods may apply.

Changing country of residence

It is important that you advise us when you change your country of residence as it may impact the cover or premium, even if you are moving to a country within your geographical area of cover. If you move to a country outside of your geographical area of cover, your existing cover will not be valid there. Please note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate. If you are in any doubt, please seek independent legal advice, as we may no longer be able to provide you with cover. The cover we provide is not a substitute for local compulsory health insurance.

Please also note that GlobalPass Plans are only available to residents of Latin America and the Caribbean. Therefore, treatment received after the policyholder has moved residence outside of Latin America and the Caribbean will not be covered.

Changing your address/email address

All correspondence will be sent to the details we have on record for you unless requested otherwise. Any change in your home, business or email address should be communicated to us in writing as soon as possible.

Correspondence

Written correspondence between us must be sent by email or post (with the postage paid). We do not usually return original documents to you, unless you specifically request us to do so at the time of submission.

Renewing membership

Subject to the provisions on "Reasons your membership would end", your annual policy is automatically renewed for the next Insurance Year provided that the plan/plan combination selected is still available, we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

As part of this automatic process, one month before the renewal date, you will receive a new Insurance Certificate along with details of any policy changes. If you do not receive your Insurance Certificate one month before your renewal date, it is important that you notify us.

Changes that we may apply at renewal

We have the right to apply revised policy terms and conditions, effective from the renewal date. The policy terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Insurance Year. We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the method or frequency of payment. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover.

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Your right to cancel

You can cancel the contract in relation to all insured persons, or only in relation to one or more dependants, within 30 days of receiving the full terms and conditions of your policy or from the start/renewal date of your policy, whichever is later. Please note that you cannot backdate the cancellation of your membership.

Should you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. This form can be sent to us via email.

@ underwriting@allianzworldwidecare.com

Alternatively, you can post this form to the Client Services Team, using the address provided at the back of this guide.

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s) premiums paid for the new Insurance Year, provided that no claims have been made. If you choose not to cancel (or amend) your policy within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment, according to the payment frequency selected by you.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Insurance Certificate) will end:

- If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.
- If you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" for further details.
- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding whether they can join the scheme, the applicable premium to pay or whether we have to pay a claim. Please see the section on "Additional terms" for further details.
- If you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on "Your right to cancel" for further details.

If your membership ends for reasons other than for fraud/non-disclosure, we will refund any premiums you have paid which relate to a period after your membership has ended, subject to the deduction of any money which you owe us.

Please note that if your membership ceases, your dependant's cover will also end.

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. Any eligible expenses incurred during the period of cover shall be reimbursed up to six months after the expiry date of the policy. However, any on-going or further treatment that is required after the expiry date of your policy will no longer be covered.

ADDITIONAL TERMS

The following are important additional terms that apply to your policy with us:

1. **Applicable law:** Your membership is governed by the Irish law unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in Ireland.
2. **Economic sanctions:** This policy does not provide any cover or benefit for any business or activity to the extent that either the cover, benefit, the underlying business or activity would violate any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.
3. **Liability:** Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsements. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.
4. **Other parties:** No other person (except an appointed representative) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing by us.
5. **Third party liability:** If you or any of your dependents are eligible to claim benefits under a public scheme or any other insurance policy or from any other third party, which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. You must inform us and provide all necessary information if and when you are entitled to claim benefits under a public scheme or any other insurance policy or from any other third party. You and the third party may not agree any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise, we are entitled to recover the amounts paid from you and to cancel the policy. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made or due under a public scheme or any other insurance policy or made by or due from any other third party.
6. **Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labor unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.
7. **Fraud:**

a) Incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising between completing the relevant application form and the start date of the policy will be deemed to be pre-existing and will not be covered if not

disclosed. If the applicant is not sure whether something is material, the applicant is obliged to inform us. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

b) If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

8. **Cancellation:** We will cancel the policy where you have not paid the full premium due and owing. We shall notify you of this cancellation and the contract shall be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

9. **Making contact with dependents:** In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependent on a policy (e.g. when we need to collect an email address for an adult dependent), the policyholder, acting for and on behalf of the dependent, may be contacted by us and asked to provide the relevant information, provided that these are non-sensitive medical information relating to a dependent. Similarly, any non-medical information in relation to a person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder.

10. **Use of Medi24:** Please note that the Medi24 and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied upon for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that we are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the Medi24 will be recorded and may be monitored for training, quality and regulatory purposes.

DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit:

www.allianzworldwidecare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy of our full Data Protection Notice.

+353 1 630 1301

If you have any queries about how we use your personal data, you can always contact us by email.

AP.EU1DataPrivacyOfficer@allianz.com

COMPLAINTS AND DISPUTE RESOLUTION PROCEDURE

Making a complaint

Our Helpline is always the first number to call if you have any comments or complaints. If we have not been able to resolve the problem on the telephone, please email or write to us at:

+353 1 630 1301

client.services@allianzworldwidecare.com

Customer Advocacy Team, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

We will handle your complaint according to our internal complaint management procedure detailed at:

www.allianzworldwidecare.com/complaints-procedure

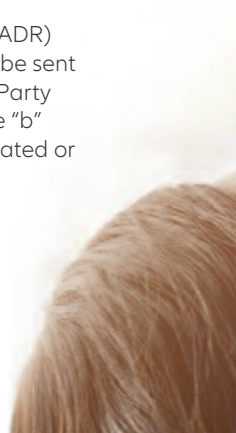
You can also contact our Helpline to obtain a copy of this procedure.

Mediation

1. Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.

2. If differences cannot be resolved in accordance with Clause "a" above, the parties shall attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is US$600,000 or less and which cannot be settled amicably between the parties. The parties shall endeavour to agree on the appointment of an agreed Mediator. Should the parties fail to agree the appointment of an agreed Mediator within 14 days, either party, upon written notice to the other party, may apply to CEDR for the appointment of a Mediator.

   To initiate the mediation, a party must give notice in writing (Alternative Dispute Resolution (ADR) Notice) to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause "b" until it has attempted to settle the dispute by mediation and either the mediation has terminated or



the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in the country of the Applicable Law. The Mediation Agreement referred to in the Model Procedure shall be governed by, and construed and take effect in accordance with the laws of the country of the Applicable Law. The Courts of the country of the Applicable Law shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:

   - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of US$600,000, or

   - Referred to mediation pursuant to Clause "b" but not voluntarily settled by mediation within three months of the ADR Notice date

   shall be determined exclusively by the Courts of the country of the Applicable Law and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause "c" shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

Legal action

You shall not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.

DEFINITIONS

The following definitions apply to the benefits included in our range of Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any unique benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever the following words/phrases appear in your policy documents, they will always be defined as follows:

A

Accident is a sudden, unexpected event which causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accommodation costs for one parent staying in hospital with an insured child under 18 refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers.

Acute refers to sudden onset.

B

Bariatric Surgery refers to surgical procedures aimed to achieve weight loss, out of medical necessity. The surgical procedures we cover are: gastric bypass surgery, sleeve gastrectomy surgery, biliopancreatic diversion (with or without duodenal switch) and laparoscopic adjustable silicone gastric banding surgery. It also refers to all pre and post-surgery assessments, consultations and any complications thereafter, up to the benefit limit. Cover is only provided where all the following conditions are met: Cover is only provided where all the following conditions are met:

1. The insured person has a BMI of 40 or above, or a BMI between 35 and 40 in addition to two of the following significant diagnoses that could be improved with weight loss: Hypertension, Type 2 Diabetes Mellitus, Hypercholesterolemia, Ischemic Heart disease.
2. The insured person has tried all appropriate non-surgical measures but has failed to achieve or maintain adequate, clinically beneficial weight loss for at least one year. All efforts and compliance with healthy eating and regular exercise need to be proven to Allianz Care.
3. The insured person has received, or will be receiving intensive management in a specialist obesity service. We have the right to decide if an obesity clinic/bariatric surgeon is operating as a reasonable specialist obesity service.
4. The insured person is deemed fit for anesthesia and surgery as decided by our medical director.
5. The insured person commits to the need for long-term follow up and supervision.

Our medical director reserves the right to decline cover for Bariatric surgery if considered as non-medically necessary.

C

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. This benefit only includes chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

Complications of childbirth refer to conditions that arise during childbirth and that require a recognized obstetric procedure. Complications of childbirth also refer to medically necessary Cesarean sections. This benefit is only covered for policies with 2 adults (not including dependent children).

Complications of pregnancy relate to the health of the mother and to complications that arise during the pre-natal stages of pregnancy. This benefit is only covered for policies with 2 adults (not including dependent children).

Congenital Condition refers to any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not. This includes, but is not limited to, conditions such as hair lip or cleft palate.

Co-payment is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits.

D

Day-care treatment is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. We offer two types of deductibles: "per person" and "per family". The "per person" deductible applies to policies covering a single insured person with up to one dependent; this deductible applies separately to each person included in the policy. The "per family" deductible applies to policies covering a family (i.e. three or more insured persons); this deductible is applied collectively to all persons included in the policy. Please note that both types of deductible apply per Insurance Year: therefore, if your claim is towards the end of the Insurance Year and treatment continues over the renewal date, the annual deductible will be payable for treatment received in each Insurance Year.

Benefits that are subject to the deductible are listed in your Table of Benefits with an A.

If you also have local insurance in place (with another healthcare insurer), you can request that any eligible in-patient/day-care claims paid for by the local healthcare insurer are accepted as a contribution to the deductible amount on your healthcare plan with us. This only applies to eligible in-patient/day-care treatment received in a hospital or clinic.

Please refer to the Claims section for more information.

Dental prescription drugs are those prescribed by a dentist for the treatment of a dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country. This does not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental prostheses include crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery includes the surgical extraction of teeth, as well as other tooth related surgical procedures such as apicectomy and dental prescription drugs. All investigative procedures necessary to establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover any surgical treatment that is related to dental implants.

Dental treatment includes an annual checkup, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dependent is your spouse or partner (including same sex partner) and/or unmarried children (including any step, fostered or adopted children) financially dependent on the policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance Certificate as one of your dependents.

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

Doctor Fees refer to fees for consultations, including medical practitioner and specialist fees, incurred in respect of out-patient treatment.

Direct family history exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

E

Emergency constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment refers to acute emergency dental treatment due to a serious accident requiring hospitalization. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency out-patient dental treatment is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth, including pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. The treatment must be received within 24 hours of the emergency event. This does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment.

Emergency treatment outside area of cover is treatment for medical emergencies which occur during business or holiday trips outside your area of cover (or outside country of residence for those with Worldwide cover). Cover is provided up to a maximum period of six weeks per trip within the maximum benefit amount and includes treatment required in the event of an accident, or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a physician, medical practitioner or specialist must commence within 24 hours of the emergency event. Cover is not provided for any curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover, nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. Please advise us if you are moving outside your area of cover for more than six weeks.

Expenses for one person accompanying an evacuated person refer to the cost of one person travelling with the evacuated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation originated. Cover does not extend to hotel accommodation or other related expenses.

F

Family refers to the policyholder with two or more legal dependents.

Family history exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

H

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Checks are limited to:

- Physical examination.
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
- Neurological examination (physical examination).
- Cancer screening:
  - Annual pap smear.
  - Mammogram (every two years for women aged 45+, or earlier where a family history exists).
  - Prostate screening (yearly for men aged 50+, or earlier where a family history exists).
  - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists).
  - Annual fecal occult blood test.
- Bone densitometry (every five years for women aged 50+).
- Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).
- BRCA1 and BRCA2 genetic test (where a direct family history exists and where included in your Table of Benefits).

Hereditary condition refers to any abnormality, deformity, disease or illness that has been passed down through the generations of the person's family. This includes, but is not limited to, Sickle Cell anemia and Huntington's Chorea.

Home country is the declared country to which the insured person would want to be repatriated.

Home visits are consultations provided by a medical practitioner, physician or therapist in the home of the insured person. Home visits will be reimbursed at the same rate as a visit to the medical practitioner/physician/therapist's office. Amounts over and above this will only be reimbursed if it is deemed that a home visit was medically necessary i.e. following the sudden onset of an acute illness, the insured person was rendered incapable of visiting the medical practitioner, physician or therapist at their office.

Hospital is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centers and health resorts.

Hospital accommodation refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long term care are examples of in-patient benefits which include cover for hospital accommodation costs, up to the benefit limit stated, where included in your plan.

I

In-patient treatment refers to treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate is a document outlining the details of your cover and is issued by us. It confirms that an insurance relationship exists between you and us.

Insurance Year applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends exactly one year later.

Insured person is you and your dependents as stated on your Insurance Certificate.

L

Laser eye treatment refers to the surgical improvement of the refractive quality of the cornea using laser technology, including necessary pre-operative investigations.

Living donor medical costs refer to donor medical expenses for organ transplants carried out as in-patient or day-care treatment. It also includes all necessary testing to determine compatibility, once a potential donor has been identified. Costs will be covered only in cases where the member is the recipient of the donor organ.

Local ambulance is ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Long term care refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.

M

Medical evacuation applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical center (which may or may not be located in the insured person's home country) by ambulance, helicopter or airplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to the medical condition. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

If medical necessity prevents the insured person from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

Where an insured person has been evacuated to the nearest appropriate medical center for **ongoing treatment**, we will agree to cover the reasonable cost of hotel accommodation comprising of a private room with en-suite facilities. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest appropriate medical center and the principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, endeavor to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavor to do this when our medical experts so advise. Neither we nor our agents accept any liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

Members must contact us at the first indication that an evacuation is required. From this point onwards we will organize and coordinate all stages of the evacuation until the insured person is safely received into care at their destination.

In the event that evacuation services are not organized by us, we reserve the right to decline all costs incurred.

Medical necessity refers to medical treatment, services or supplies that are determined to be medically necessary and appropriate. They must be:

a) Essential to identify or treat a patient's condition, illness or injury.
b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they form part of your cover.
d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
e) Proven and demonstrated to have medical value. This does not apply to complementary treatment methods if they form part of your cover.
f) Considered to be the most appropriate type and level of service or supply.
g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
h) Provided only for an appropriate duration of time.

In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.

Medical practitioner is a physician who is licensed to practice medicine under the law of the country in which treatment is given and where he/she is practicing within the limits of his/her license.

Midwife fees refer to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has fulfilled the necessary training and passed the necessary state examinations.

N

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own policy. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first

three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Nursing at home or in a convalescent home refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the insured person to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care (see palliative care and long term care definitions).

Nutritionist is a qualified individual holding a degree or postgraduate degree recognized for state registration or who is qualified and licensed under the law of the country in which the treatment is being given.

O

Obesity is diagnosed when a person has a Body Mass Index (BMI) of over 30 (a BMI calculator can be found on our website: www.allianzworldwidecare.com/members).

Occupational therapy refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

Oculomotor therapy is a specific type of occupational therapy that aims to synchronize eye movement in cases where there is a lack of coordination between the muscles of the eye.

Oncology refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. We will also cover the cost of a wig in the event of hair loss as a result of cancer treatment.

Oral and maxillofacial surgical procedures refer to surgical treatment performed by an oral and maxillofacial surgeon in a hospital as a treatment for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumors. Please note that surgical removal of impacted teeth, the surgical removal of cysts and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless a Dental Plan has also been selected.

Organ transplant is the surgical procedure in performing organ and/or tissue transplants that has been approved by the Food and Drug Administration (FDA), and is subject to all the terms, provisions and exclusions of the policy. This benefit covers medically necessary prescribed medication needed for pre and post transplant treatment and the surgical procedure, up to the benefit limit stated in your Table of Benefits. The costs associated with organ, cell or tissue procurement, transportation and harvesting are also covered: please note that a separate benefit limit may apply to these, as well as to any complications or consequences of them. We only pay for organ transplants that are required as a result of an eligible condition.

Orthodontics is the use of devices to correct malocclusion and restore the teeth to proper alignment and function. We only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the 'Orthodontic treatment and dental prostheses' benefit limit.

Orthomolecular treatment refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity. Cover includes exploratory examinations and diagnostic tests carried out under anesthesia.

Out-patient treatment refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require the patient to be admitted to hospital.

P

Palliative care refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

Periodontics refers to dental treatment related to gum disease.

Podiatry Refers to medically necessary treatment carried out by a State Registered podiatrist.

Policyholder is the person appearing first in the Insurance Certificate.

Post-natal care refers to the routine post-partum medical care received by the mother, up to six weeks after delivery. This

benefit is only covered for policies with 2 adults (not including dependent children).

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependents could reasonably have been assumed to have known, or where pre-existence is clearly supported by one of three pre-defined sources of internationally published medical evidence (PubMed: www.ncbi.nlm.nih.gov/PubMed, ELSEVIER: www.elsevier.com or Uptodate: www.uptodate.com), will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. Please refer to the "Additional information" section of your Table of Benefits to confirm if pre-existing conditions are covered.

Pregnancy refers to the period of time, from the date of first diagnosis, until delivery.

Pre-natal care includes common screening and follow up tests as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis. This benefit is only covered for policies with 2 adults (not including dependent children).

Prescribed glasses and contact lenses including eye examination refers to cover for a routine eye examination carried out by an optometrist or ophthalmologist (one per Insurance Year) and for lenses or glasses to correct vision.

Prescribed medical aids refers to any device which is prescribed and medically necessary to enable the insured person to function to a capacity consistent with everyday living where reasonably possible. This includes:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long term wound aids such as dressings and stoma supplies.

Costs for medical aids that form part of palliative care or long term care (see palliative care and long term care definitions) are not covered.

Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a medical practitioner. An initial assessment report must be reviewed by our medical services department in advance of treatment to decide if treatment is medically necessary. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new progress report must be submitted to us after every set of 12 sessions, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

Prescription drugs refers to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country.

Preventative surgery refers to prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventative surgery when an insured person:

- Has a direct family history of a disease which is part of a hereditary cancer syndrome, for example, breast cancer or ovarian cancer, and
- Genetic testing has established the presence of a hereditary cancer syndrome

Preventive treatment refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth.

Principal country of residence is the country where you and your dependents (if applicable) live for more than six months of the year.

Psychiatry and psychotherapy is the treatment of mental disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or in-patient admissions must include prescription medication related to the condition. Psychotherapy treatment (on an in-patient or out-patient basis) is only covered where you or your dependents are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. In addition, out-patient psychotherapy treatment (where covered) is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

R

Rehabilitation is treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness, injury or surgery. The rehabilitation benefit is only payable for treatment that starts within 14 days of discharge after the acute medical and/or

surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

Repatriation of mortal remains is the transportation of the insured person's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorizations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered unless this is listed as a specific benefit in your Table of Benefits.

Routine maternity refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labor only) as well as newborn care. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary Cesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan. This benefit is only covered for policies with 2 adults (not including dependent children).

S

Second Medical Opinion refers to the process of seeking an evaluation by another medical professional to confirm the diagnosis and treatment plan of a primary physician, or to offer an alternative diagnosis and/or treatment.

Specialist is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

Specialist fees refer to non-surgical treatment performed or administered by a specialist.

Specialized out-patient drugs drugs refers to highly specialized drugs that are used to treat the following chronic conditions: multiple sclerosis, rheumatoid arthritis, hemophilia, H.I.V., psoriasis, inflammatory bowel disease (IBD) and Hepatitis C. The prescription drugs must be clinically proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country. The benefit excludes any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven based on generally accepted medical practice.

Speech therapy refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Stem cell storage refers to the costs for extraction and one year preservation of stem cells. The benefit limit applies to the insured mother per pregnancy. No travel or accommodation costs will be covered if the stem cell storage service is not available in the country where the baby is being delivered.

Surgical appliances and materials are those which are required for the surgical procedure. These include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist is a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.

Travel costs of insured family members in the event of an evacuation refer to the reasonable transportation costs of all insured family members of the evacuated person, including but not limited to, minors who might otherwise be left unattended. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. Cover does not extend to hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains refer to reasonable transportation costs of any insured family members who had been residing abroad with the deceased insured person, to return to the home country/chosen country of burial of the deceased. Cover does not extend to hotel accommodation or other related expenses.

Treatment refers to a medical procedure needed to cure or relieve illness or injury.

W

Waiting period is a period of time commencing on your policy start date (or effective date if you are a dependent), during which you are not entitled to cover for particular benefits. Your Table of Benefits will indicate which benefits are subject to waiting periods.

We/Our/Us Is Allianz Care.

Y

You/Your refers to the eligible individual stated on the Insurance Certificate.

EXCLUSIONS

Although we cover most medically necessary treatment, expenses incurred for the following treatments, medical conditions, procedures, behaviors or accidents are not covered under the policy unless confirmed otherwise in the Table of Benefits or in any written policy endorsement.

Acquisition of an organ and technical or animal organs
Organ transplants involving technical or animal organs and expenses incurred during the acquisition of an organ relating to stem cell storage and banking.

Behavioral and personality disorders
Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behavior, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders or treatments that encourage positive social-emotional relationships, such as family therapy, unless indicated otherwise in the Table of Benefits.

Chemical contamination and radioactivity
Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Complementary treatment
Complementary treatment, with the exception of those treatments indicated in the Table of Benefits.

Complications caused by conditions not covered under your plan
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

Consultations performed by you or a family member
Consultations performed, as well as any drugs or treatments prescribed, by you, your spouse, parents or children.

Dental veneers
Dental veneers and related procedures.

Developmental delay
Developmental delay, unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12 month delay in cognitive and/or physical development.

Drug addiction or alcoholism
Care and/or treatment of drug addiction or alcoholism (including detoxification programs and treatments related to the cessation of smoking), instances of death, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

Experimental or unproven treatment or drug therapy
Any form of treatment or drug therapy which is experimental or unproven from an evidence based perspective and/or is not approved by the Food and Drug Administration of the USA for the medical condition in question.

Eye examinations
Eye examinations carried out by optometrists or ophthalmologists, unless otherwise stated in the Table of Benefits.

Failure to seek or follow medical advice
Treatment required as a result of failure to seek or follow medical advice.

Family therapy and counseling
Costs in respect of a family therapist or counselor for out-patient psychotherapy treatment.

Fees for the completion of a Claim Form
Medical practitioner fees for the completion of a Claim Form or other administration charges.

Gastric balloon
Gastric balloon surgery/treatment, vagus nerve blocking/Maestro rechargeable system or any complications of bariatric surgery where the original surgery was not covered by us.

Genetic testing
Genetic testing, except:

a) where specific genetic tests are included within your plan;

b) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over;

c) testing for genetic receptor of tumors, which is covered.

General nursing care
Hospitalization that is required for the purpose of general nursing care or any other purpose other than for receiving treatment covered by your membership.

Injuries caused by professional sports
Treatment or diagnostic procedures for injuries arising from an engagement in professional sports.

Intentionally caused diseases or self-inflicted injuries
Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

Loss of hair and hair replacement
Investigations into, and treatment of, loss of hair and any hair replacement unless the loss of hair is due to cancer treatment.

Medical error
Elective treatment required as a result of medical error.

Moving residence outside of Latin America
Treatment received after the policyholder has moved residence outside of Latin America and the Caribbean, as GlobalPass Plans are only available to residents of Latin America and the Caribbean.

Obesity treatment
Investigations into, and treatment of, obesity except where the Bariatric surgery benefit forms part of your plan.

Out-patient treatment
Treatment received on an out-patient basis when an Out-patient Plan does not form part of your cover (i.e. treatment in the practice or surgery of a medical practitioner, therapist or specialist or emergency room that does not require the patient to be admitted to hospital), except for out-patient treatment that is included as part of the Core Plan e.g. CT, MRI and PET scans.

Orthomolecular treatment
For the orthomolecular treatment, please refer to Orthomolecular definition.

Participation in war or criminal acts
Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

Plastic surgery
Any treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership.

Pre- and post-natal
Pre- and post-natal classes.

Pre-existing conditions
Pre-existing conditions (including any pre-existing chronic conditions) which are indicated on a Special Conditions Form that is issued prior to policy inception (if relevant) and conditions which have not been declared on the relevant application form. In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

Prescribed medical aids
Costs related to the supplying and fitting of prescribed medical aids, unless stated otherwise in your Table of Benefits.

Products sold without prescriptions
Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

Refractive surgery
Treatment to change the refraction of one or both eyes, including but not limited to refractive keratectomy (RK) and photorefractive keratectomy (PRK), unless otherwise indicated in your Table of Benefits.

Sex change
Sex change operations and related treatments.

Sleep disorders
Treatment of sleep disorders, including insomnia, obstructive sleep apnea, narcolepsy, snoring and bruxism.

Speech therapy
Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

Stays in a cure center
Stays in a cure center, bath center, spa, health resort and recovery center, even if the stay is medically prescribed.

Sterilization, sexual dysfunction and contraception
Investigations into, treatment of and complications arising from sterilization, sexual dysfunction (unless this condition is as a result of total prostatectomy following surgery for cancer) and contraception including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

Surrogacy
Treatment directly related to surrogacy, whether you are acting as surrogate, or are the intended parent.

Termination of pregnancy
Termination of pregnancy, except in the event of danger to the life of the pregnant woman.

Travel costs
Travel costs to and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under local ambulance and medical evacuation benefits.

Treatment in the USA
Treatment in the USA if we know or suspect that cover was acquired for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were

apparent to the insured person prior to acquiring cover. If any claims have been paid by us in these circumstances, we reserve the right to seek reimbursement from the insured person of any amounts which have already been paid in claims.

Treatment outside the geographical area of cover
Treatment outside the geographical area of cover unless for emergencies or authorized by us.

Triple/Bart's, Quadruple or Spina Bifida tests
Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

Tumor marker testing
Tumor marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case, cover will be provided under the Oncology benefit.

Vessel at sea
Medical evacuation from a vessel at sea to a medical facility on land.

Vitamins or minerals
Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are not covered, unless a specific benefit is included within your Table of Benefits.

Treatments not indicated in your Table of Benefits
The following treatments, expenses, procedures or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Complications of pregnancy and complications of childbirth.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Diagnostic tests.
- Doctor fees.
- Emergency dental treatment.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Nursing at home or in a convalescent home.
- Nutritionist consultations.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Palliative care.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Prescribed physiotherapy, speech therapy, oculomotor therapy, occupational therapy, chiropractic therapy, osteopathy, homeopathy, acupuncture and podiatry.
- Prescription drugs.

- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity.
- Travel costs of insured family members in the event of an evacuation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.

NOTES

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:

24/7 Helpline for general enquiries and emergency assistance

English:	+353 1 630 1301
German:	+353 1 630 1302
French:	+353 1 630 1303
Spanish:	+353 1 630 1304
Italian:	+353 1 630 1305
Portuguese:	+353 1 645 4040

Toll free numbers: www.allianzworldwidecare.com/toll-free-numbers

Please note that in some instances the toll-free numbers are not accessible from a mobile phone. In this case, please dial one of the Helpline numbers listed above.

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes. Please note that only the policyholder (or an appointed representative) can make changes to the policy. Security questions will be asked of all callers to verify their identity.

Email: client.services@allianzworldwidecare.com

Fax: + 353 1 630 1306

Address: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

www.allianz-care.com

www.facebook.com/allianzcare

www.youtube.com/user/allianzworldwide

www.linkedin.com/company/allianz-care

DOC-IBG-GP-en-US-0419